

AB021. Doctor-patient sexual communication

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Abstract: Sexual dysfunction is often associated with physical, psycho-social and emotional factors. It is a multi-causal and multidimensional problem incorporating the biological, psychological and interpersonal factors. For patients with sexual dysfunction, their sexual and social life has been physically disconcerting, emotionally distressing and socially disruptive. Sexual dysfunctions can be a symptom of deep-seated personality conflict. It is clear that psychosocial factors play an important role, be it causative or as a consequent of sexual dysfunction. With the increasing awareness of the role of psychosocial factors, a variety of therapeutic approaches in the treatment of sexual dysfunction has been developed. Apart from the comprehensive and detailed sexual and psychosocial history, physical examination and other laboratory tests, psychosexual counseling and sex therapy is deemed pertinent for sexual dysfunction with a psychosocial or behavioral origin, as majority of these sexual dysfunction stem from psychological, social and attitudinal determinants. Psychosexual counseling together with sex therapy has entered into the mainstream medical professional world since the publication of Master and Johnson's Human Sexual Inadequacy in the 1970s. This lecture gives an overview of the principles of psychosexual counseling and the PLISSIT model of sex therapy in the treatment of sexual dysfunction. It is important that healthcare providers become knowledgeable and comfortable in the psychosocial evaluation and treatment of sexual dysfunction, so as to increase the quality of life of these patients.

Keywords: Sexual dysfunction; deep-seated personality conflict; psycho-social evaluation

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AB022. The psyche of male sexual difficulties related to related to the partner

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Abstract: Impression management for men aiming at courtship and love is cognitively taxing and is costly. Recent research suggests that when a man tries to impress an attractive woman his cognitive performance could be impaired and depleted. However, cognitive performance of a woman is not affected during her interaction with someone of the opposite sex (Karremans *et al.* 2009). By dictation of nature and anatomically too, men take an active and positive role in sexual performance; their failures in sexual performances will be revealed to the partner then and there. Men react negatively to such a failure when their confidence or self-esteem are at stake. Their psyche will strike it as a failure of life time, failure of their genetic spread and survival of the species. In subsequent sexual encounter their body and subconscious mind will switch to the physiology of anti-erectile transmission and limit the expansion of desire and arousal on other attempts. In general, we call this performance anxiety. Masters and Johnson's pioneering work in the 70's highlighted the negative impact of performance anxiety on sexual function. As a form of therapy, exercise such as Sensate Focus were designed for the couple to overcome the performance anxiety and phobic quality in man so that sexual arousal and penetrative erection can be practiced/achieved in a relaxed state. At the Fertility, menopausal and andrology settings of OBGYN, it is not uncommon to see male sexual dysfunctions that include lack of desire, psychogenic ED and ejaculatory dysfunctions. One of the main causes of complaints of unconsummated marriages is vaginismus (and dyspareunia) in the partner which causes psychogenic erectile dysfunction in husbands who fail to penetrate at the first or second attempts. Such couple tend to drift from sexual intimacy for months and years until there is an extended family pressure for conception. Another situation that compromises erectile capacity of otherwise a normal

man with routine sexual performance is the demand from wife to perform at a fixed date during the ovulation time. Significant proportion of the sexual dysfunctions are also related to the interpersonal relationship issues. Desire and frequency of sexual episodes and erectile and ejaculatory functions suffer a dip when anger, emotional injury or disappointment and frustration accumulate and linger in the couples' relationship. Resentment works against intimacy and trust. Some men are more sensitive and averse towards partners' body image, odor and excessive lubrication or more frequent demands for sexual intimacy. Such men tend to avoid or may fail when attempting sex with the partner. Some others are able to get full erection during self-masturbation but could not achieve erectile capacity for intravaginal intercourse or ejaculation. Some men also shut off completely their interest for sexual engagement after witnessing a spontaneous abortion or a delivery of the baby. Some other situation where men buckled themselves from engaging in sexual activity include: after being belittled about sexual performance or hinted that penis is not up to the mark in size; wife being very shy and not reciprocating sexual desire or interest or dominant in the power play; chronic illnesses, pelvic prolapse and incontinence in partner, etc. Men who are used to unusual masturbatory technique and ejaculation also find themselves suffering from intravaginal anejaculation. Each and every couples are different. Treatment approaches should be individualistic and global with sex therapy, pharmacotherapy and hormonal adjustment if necessary.

Keywords: Psychogenic erectile dysfunction; sexual performance

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AB023. Penile augmentation surgery: characteristics of artificial graft material and preoperative preparation

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Abstract: Penile augmentation surgical procedure includes diverse graft materials such as artificial collagen material as well as dermo-fat graft. Important factors of postoperative satisfaction are natural appearance of genitalia at the flaccid state and minimal resorption of graft volume. Artificial collagen materials and acellular dermal matrix are available for surgical procedure with variable size. History of penile augmentation surgery: Pediatric penile surgical procedure for lengthening and reconstructive surgery was developed as penile plastic surgical procedure combined with dermo-fat graft. In 1971, Kelly, Eraklis *et al.* reported preservation of dorsal neurovascular bundle and division of corporal crus from ischiopubic ramus for penile lengthening procedure. In 1974, Johnson reported the surgical cases in epispadias patient as division of crus from ischiopubic ramus and penile skin graft. The procedures include division of suspensory ligament and blunt dissection of fundiform ligament. In 1970's Horton reported suprapubic fat resection and Z-plasty with anchoring on Scarpa's fascia for lengthening procedure. In 1980's several fat injection procedures in Darto's fascia have been reported for girth enhancement but they were lack of reproducibility. (1year Resorption 50%) Later reports the result of cystic nodule, lump formation and fat migration. In 1990's V-Y plasty for lengthening was reported. Historically illegal liquid injection materials with non-medical hands were reported as correction or reconstructive procedures for removal and treatment of deformed genitalia. In 1992 Horton reported flank abdominal free dermo-fat graft to Darto's fascia. This procedure showed fair graft survival rate and developed to buttock skin crease dermo-fat graft. Medical grade silicone; long-term implantable; Gortex plate, polytetrafluoroethylene (PTFE); Acellular dermal graft/(Alloderm, Surederm); Acellular xenogeniccollagen structure/(Lyoplant, Terudermis); Autologous tissue